

**Questions  
and  
Answers**

**MEDICAL  
ASSISTANCE**

**••Medicaid••**

U. S. DEPARTMENT OF  
HEALTH, EDUCATION, AND WELFARE

Social and Rehabilitation Service  
Medical Services Administration

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— Title **VI** of the Civil Rights Act of 1964 states: "No person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefit of, or be subjected to discrimination under any program or activity receiving Federal financial assistance." Therefore, the programs covered in this publication, like every program or activity receiving financial assistance from the Department of Health, Education, and Welfare, must be operated in compliance with this law.

# **Medicaid**

## **Questions / and Answers** **titl** **MEDICAL ASSISTANCE**

**U.S. DEPARTMENT OF  
HEALTH, EDUCATION, AND WELFARE**

**SOCIAL AND REHABILITATION SERVICE**

**JUNE 1968**

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## FOREWORD

In 1965 Congress added to the Social Security program begun in 1935 two significant amendments on health care and services. One, Title XVIII, established MEDICARE—a Federal program of hospital and medical insurance for nearly all people 65 and over. The other, Title xix, established MEDICAID—a Federal-State program to help provide medical services for the needy and the medically indigent. In the Federal Government, Medicaid is administered by the Medical Services Administration in the Social and Rehabilitation Service of the Department of Health, Education, and Welfare.

This second edition of *Questions and Answers—Medical Assistance "Medicaid"* incorporates the changes in the program required by the 1967 Amendments to the Social Security Act.

The information in the pamphlet has proven to be of practical everyday use to administrators of Title xix programs in the States. It has also been found useful by physicians, dentists, social workers, pharmacists, nurses, and members of the other professions whose participation and support are essential to Medicaid's ability to serve.

To all these groups we commend this new edition, inviting their continuing interest and cooperation. Anyone who needs the detailed Federal regulations or the relevant State regulations should communicate with the agency responsible for the Title xix program in his State. Copies of both Supplement D of the Federal Handbook of Public Assistance (Medical Assistance Programs Under Title xix of the Social Security Act) and the State's regulations are available in the State agency's office.

With this new edition we pledge our continuing support to those who provide, as well as to those who so urgently need, the services Medicaid makes possible.



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## **PURPOSE AND GOALS**

### **Question 1**

#### **What is medical assistance?**

Medical assistance, generally referred to as Medicaid, is a grant-in-aid program in which the Federal and State (and sometimes local) governments share the costs of medical care for people with low income. It is authorized by title XIX of the Social Security Act, signed into law by the President on July 30, 1965, as amended by the Social Security Amendments of 1967.

### **Question 2**

#### **What is the goal of the program?**

The program's ultimate goal is to make medical care of high quality readily available to those unable to pay for it.

### **Question 3**

#### **How does a State achieve this goal?**

The State sets standards that ensure care of high quality, establishes policies and procedures to achieve those standards, and makes other arrangements to help people get the care and services they need. The State agency and its local units provide social services that help people recognize the need for medical care, obtain care promptly, and resolve social problems related to medical conditions. They authorize expenditures, and make payments for the care and services given. They also work with other agencies, organizations, and professional groups to develop and maintain adequate resources to provide medical care for everyone throughout the State who is eligible.

### **Question 4**

#### **What are the basic differences between Medicaid and Medicare (health insurance for the aged)?**

Medicaid is a Federal-State program that provides medical assistance for low-income people of all ages who need care and cannot pay for it.

A State determines whether an individual or family is eligible according to its definition of need, within certain Federal limits. The program is State-administered and is financed in part by the State (or State and local) government and in part (50-83 percent, depending on the State's average per capita income) by the Federal Government. Since each State determines benefits and eligibility, within Federal guidelines, there are differences—State by State—in who is eligible and for what benefits.

Medicare is a federally administered program offering two kinds of health insurance benefits for people aged 65 or older: hospital insurance (for hospitalization and related care) and supplementary medical insurance (for physicians' services and some other medical services). Benefits are the same throughout the Nation. The hospital insurance is a right for most of the aged; it is financed by deductions from employees' wages and matching taxes paid by employers and by a tax paid by the self-employed. Medical insurance is a voluntary program, financed by monthly premiums paid by the individual and by a matching amount from the Federal Government. The Social Security Administration formulates policy and administers the program.

#### **Question 5**

##### **What is the relationship between Medicaid and Medicare?**

Medicaid complements the hospital insurance provision of Medicare by paying all or part of the deductible and coinsurance amounts for needy and low-income aged people who are insured. It also complements the voluntary medical insurance provisions of Medicare by paying the monthly premiums for beneficiaries eligible for Medicaid. Medicaid supplements the insurance program by providing additional services for people who are eligible for Medicare if the State plan so provides. After January 1, 1970, States that do not pay the Medicare premiums will not be reimbursed for any medical care costs that could be met by that program.

#### **Question 6**

##### **Are medical care and services under Medicaid available in all States?**

Not all States have programs. A few States need legislation, but programs have been established by most of the others, including some whose programs went into operation January 1, 1966—the earliest date possible. Information about the Medicaid program of a particular State is available from the State Department of Welfare or the State Department of Social Services or from the State Department of Health in States in which that agency is involved in the program.

Since Medicaid is a State-administered program, aided by Federal funds, each State decides for itself whether it wants the program, what services it will provide, and to whom. Until January 1, 1970, the Federal Government will continue to share in the cost of State programs that provide medical care to assistance recipients under the older public assistance programs. After that date, the Federal Government will not share in the cost of vendor payments for medical care except under a Medicaid plan. It is therefore anticipated that all States will adopt Medicaid programs by 1970.

## **ADMINISTRATION OF THE PROGRAM**

### **Question 7**

#### **Who administers the Medicaid program?**

At the Federal level, the Secretary of Health, Education, and Welfare is responsible for administration of Federal grants-in-aid for the State programs. Immediate responsibility at the Federal level has been assigned to the Medical Services Administration of the Social and Rehabilitation Service, Department of Health, Education, and Welfare.

At the State level, a single State agency administers the program. It may be the agency that administers the Federal-State program of old-age assistance, or it may be another agency such as the State health agency. In any case, the agency administering old-age assistance determines eligibility for the Medicaid program.

### **Question 8**

#### **What is the Medical Assistance Advisory Council?**

The Secretary of HEW, with Congressional authority, has set up an advisory council to advise him on administration of the Medicaid program (including relationships between Medicaid and Medicare) at the Federal level. The Council has 21 members, the majority of whom represent consumers of health services. State and local agencies, non-governmental organizations, and providers of medical services are among the groups concerned with health represented on the committee.

**Question 9****What is a State Medical Care Advisory Committee?**

Every State with a Medicaid program must establish a committee whose membership includes consumer representation to advise the State agency director on the program. The committee is appointed by a high State authority such as the Governor or the director of the State agency.

**Question 10****Who is appointed to the State Medical Advisory Committee, and what are the committee's functions?**

Membership should include, but is not confined to, representatives of the medical, dental, pharmaceutical, nursing, and social work professions, as well as people representing the field of mental health, home health agencies, nursing homes, schools of health science, public health and public welfare administrators, and consumer groups. Because of the program's emphasis on child health, the committee should also include at least one pediatrician and, as an ex officio member, the State director of the child health program.

The committee makes recommendations on the standards, quality, and costs of medical services, personnel, and facilities and also helps identify unmet needs and assists in long-range planning, evaluation, and utilization review. It advises, as requested, on administrative and financial matters and interprets the program and its goals to professional groups.

## **THE PEOPLE WHO BENEFIT FROM THE PROGRAM**

**Question 11****If a State has a Medicaid program, who must be covered?**

States must include:

- (1) Everyone receiving financial aid from the Federal-State public assistance programs for families with dependent children and for the aged, the blind, and the disabled.
- (2) Everyone who would be eligible for such financial assistance except that he does not meet certain State requirements pro-

**hibited by Federal law or Federal policy in the Medicaid program.**

- (3) Everyone under age 21 who, except for a State age or school-attendance requirement, would be eligible for aid to families with dependent children (AFDC).

**Question 12**

**What additional groups may be included with Federal sharing in costs?**

States may include as categorically needy the following groups of people:

- (a) People who would be eligible under one of the federally aided financial assistance programs if the State's programs were as broad as Federal legislation permits—for example, families with an unemployed father in the home in States not making AFDC payments to such families and people considered permanently and totally disabled under the Federal definition but not under the State's more restrictive definition.
- (b) Everyone who would be eligible for assistance payments if he were not a patient in a medical facility. There is one exception. A person under 65 who is a patient in a mental or tuberculosis institution is not eligible.

They may include as medically needy:

- (c) People whose income and resources are large enough to cover their daily living expenses (according to income levels set by the State) but not large enough to pay for their medical care and who are aged, disabled, blind, or members of families with dependent children; in other words, people who would be eligible for federally aided financial assistance if they had less in the way of income and resources. A State that includes people in any of these groups must include those in all four groups.
- (d) All medically needy people under age 21 even though they are not eligible for financial assistance under another federally aided public assistance program. They need not live with their parents to be eligible, and they can be children whose parents are employed but do not earn enough to pay for the children's medical care.

**Question 13**

**May a State include needy or low-income people for whom Federal sharing in costs is not authorized?**

Yes. A State may include people who are receiving general assistance under a statewide program. It may also include others—for example,

- (a) those under age 65 who are as needy as recipients of federally aided

assistance but who may not be blind or disabled or members of families with dependent children, and (b) those with income above specified amounts (see Question 25).

The Federal Government will share in the administrative costs of providing medical services to such groups if they receive care and services comparable to those provided other groups under the plan and under comparable eligibility conditions, but it cannot share in the costs of the care.

**Question 14**

**Must an eligible person accept medical care even if it is contrary to his religious beliefs?**

The Federal law explicitly provides that none of its provisions require a State to compel anyone to undergo medical screening, diagnosis, or treatment that is contrary to his religious beliefs.

However, a person applying for medical assistance on the basis of a disability (under AFDC, AB, or APTD) must submit to a medical examination to establish his eligibility.

## **ELIGIBILITY REQUIREMENTS**

**Question 15**

**Who is eligible for Medicaid?**

Recipients of money payment under one of the State's federally aided public assistance programs and others who would be eligible for financial assistance except that they do not meet certain State conditions—durational residence requirements, for example—are automatically eligible. A State may also include the "medically needy"—people who otherwise would qualify for public assistance under one of the four categories and whose income is considered high enough to meet daily living expenses but not high enough to meet medical bills.

**Question 16 Who  
may apply?**

Anyone who wishes to apply must have an opportunity to do so. Application should be made to the local public welfare agency.

**Question 17****When does a person's eligibility begin?**

It must begin no later than the date of application if he meets all the eligibility requirements as of that date. A State plan may permit eligibility to 'be retroactive for as long as 3 months before the month when application was made.

**Question 18****How frequently will eligibility be redetermined?**

Eligibility will be determined periodically at intervals set by the State, but at least every 12 months. It must be reconsidered (a) when the agency has information about anticipated changes in the individual's situation and (b) within 30 days after changes in his situation have been reported to the agency.

**Question 19****Can the wife (or husband) of a person receiving federally aided financial assistance be eligible for medical assistance even though she herself could not meet the qualifying conditions?**

Yes. States may include the wife (or husband) of a person receiving old-age assistance, aid to the blind, or aid to the permanently and totally disabled if she is living with the recipient and is essential to his welfare and if her needs are considered in determining the amount of his cash payment. Thus the wife (or husband) of an old-age assistance recipient who is not eligible for cash assistance because she is under age 65 could be eligible for medical assistance.

**Question 20****How are a person's rights protected in the eligibility determination process?**

In determining eligibility, States must establish reasonable standards that are consistent with simplicity of administration and the recipients' best interests. The procedures must meet the legal requirements of fair treatment for individuals and prompt action on applications. Practices that violate the individual's privacy or personal dignity, harass him, or violate his constitutional rights are prohibited.

**Question 21****Can States use a declaration form to simplify eligibility determination?**

Yes. However, verifications "reasonably necessary to ensure that expenditures under the program will be legal" must be made. The State's regular system for reviewing the validity of the eligibility



determination is to be used in all cases, including those where a declaration form has been used.

**Question 22**

**How much time does the State have to decide on eligibility for applicants who are not receiving money payments under one of the Federal-State public assistance programs?**

States must ensure that, in general, applications are acted on promptly—at least within 30 days—and that immediate care is given in an emergency.

**Question 23**

**Must a person have lived in the State any specified time to qualify for Medicaid?**

No. A State program cannot require that a person shall have lived in the State for a specified period of time. It must include everyone who is a resident of the State—that is, everyone who is living in the State and is not merely a transient or a visitor from another State—and is otherwise eligible. A child is "residing in the State" if his home is in the State. Temporary absences do not interrupt continuity of residence. A State may, if it wishes, include nonresidents.

**Question 24**

**Can a person receive medical assistance in a State other than his own?**

Yes. Anyone who is eligible must be provided with medical care and services, at least in a medical emergency, when he is temporarily absent from his home State and when travel to return there or postponement of care would endanger his health. Under some circumstances, medical care outside a patient's own State is authorized.

**Question 25**

**How much income can individuals or families have and still be eligible for Medicaid?**

The amount depends on the State. If the State provides medical assistance to people whose income is large enough to meet their daily living expenses but not large enough to meet the medical expenses—the "medically needy"—it must establish income levels that it will recognize as necessary for maintenance costs. For Federal sharing, the established levels cannot exceed a Federally specified proportion of the State's AFDC payment level. For most states the proportions are as follows: 150% for the second half of 1968, 140% for 1969, and 133 1/3% thereafter.

**Question 26**

**Does the amount defined by the State as "necessary for everyday living expenses" vary?**

Yes. The levels of income defined by the State as necessary for daily living expenses must be comparable for families of various sizes—that is, the amount considered essential for maintenance must provide a similar level of living for individuals and for families of various sizes.

The amount may also vary with the place of residence—an urban (city) or rural (country) area.

**Question 27**

**What happens if a family has *an* income higher than that set by the State?**

Income above the established level is considered available to meet medical costs—first, for medical insurance premiums and other medical care not covered by the State's Medicaid program, and second, for medical care that may be covered.

**Question 28**

**Is someone who owns or is buying a home eligible for Medicaid?**

Generally, States specify that a person may keep his home and still be eligible.

**Question 29**

**Are self-employed people eligible?**

Whether a person is self-employed or works for an employer has no bearing on his eligibility. A person can receive Medicaid services if he meets all criteria for eligibility including limitations on income and resources.

**Question 30**

**What property or savings can a person keep and still be eligible for Medicaid?**

Each State decides how much property a person can hold and not use toward costs of medical care. It usually includes, in addition to a home, a modest amount of savings and/or life insurance and a car of moderate value.

The State must permit the amount of savings or insurance that can be held to vary with the size of family. Anything over the amount that the State designates as not to be considered available for medical care costs must be applied toward those costs.

**Question 31**

**Can relatives be held responsible for payment of medical care costs under the program?**

Only the husband or wife of an individual or the parents of a person who is under age 21 or blind or totally disabled can be held responsible for paying the costs of the medical care provided.

**Question 32**

**Can a lien be placed on a home or other property because of the medical assistance paid for a family or individual?**

No liens or encumbrances of any kind can be imposed before an individual's death on his real or personal property because of medical assistance paid (or to be paid) on his behalf, or at any time if he was under age 65 when he received the assistance. An exception may be made if a court decides that benefits have been incorrectly paid.

Adjustments or recovery for medical assistance correctly paid can be sought only from the estate of an individual who was aged 65 or older when he received such assistance, and then only (1) after the death of his surviving spouse, if any, and (2) when he has no surviving child who is under age 21 or is blind or permanently and totally disabled.

## **MEDICAL CARE AND SERVICES PROVIDED**

**Question 33**

**What services are covered by the Federal Medicaid legislation and may be included in a State plan?**

States may include the following services:

- (1) inpatient hospital services (other than services in an institution for tuberculosis or mental diseases)
- (2) outpatient hospital services
- (3) other laboratory and X-ray services
- (4) (a) skilled nursing-home services for people 21 or older  
(b) effective July 1, 1969, early and periodic screening, diagnosis, and treatment of physical and mental defects in eligible people under 21

- (5) physicians' services (in the office, patient's home, hospital, skilled nursing home, or elsewhere)
- (6) medical care, or any other type of remedial care recognized under State law, furnished by licensed practitioners within the scope of their practice as defined by State law
- (7) home health-care services
- (8) private-duty nursing services
- (9) clinic services
- (10) dental services
- (11) physical therapy and related services
- (12) prescribed drugs, dentures, and prosthetic devices; and eye glasses prescribed by a physician skilled in diseases of the eye or an optometrist, whichever the patient may select
- (13) other diagnostic, screening, preventive, and rehabilitative services
- (14) inpatient hospital services and skilled nursing-home services for individuals aged 65 or over in an institution for tuberculosis or mental diseases
- (15) any other medical care and any other type of remedial care such as transportation to receive services, family planning services, whole blood when not otherwise available, Christian Science practitioners' services and care in Christian Science sanatoria, skilled nursing-home services for people under 21, emergency hospital services, personal care services in a patient's home prescribed by a physician.

**Question 34**

**What medical services must States provide for the categorically needy?'**

For the categorically needy, States must provide the following services:

- (1) inpatient hospital services (other than services in an institution for tuberculosis or mental diseases) paid on a reasonable cost basis
- (2) outpatient hospital services
- (3) other laboratory and X-ray services
- (4) (a) Skilled nursing-home services (other than services in an institution for tuberculosis or mental diseases) for individuals 21 years of age or older, and  
(b) effective July 1, 1969, for individuals under age 21 eligible under the plan such periodic screening and diagnostic services as are needed to identify physical and mental defects, and provide health care treatment and other measures designed to correct or ameliorate defects and chronic conditions, as may be provided in regulations of the Secretary

- (5) physicians' services, whether furnished in the office, the patient's home, a hospital, a skilled nursing home, or else where
- (6) effective July 1, 1970, home health services for *any* individual who, under the State plan, is entitled to skilled nursing-home services

**Question 35**

**What medical services must States provide for the medically needy?**

In regard to the medically needy, certain choices are open to the States. They may provide the first five of the services listed in Question 34, or they may provide any seven of the first 14 services listed in Question 33. If either inpatient hospital care or skilled nursing-home services is included among these seven, physicians' services must be provided for individuals while they are in a hospital or nursing home.

Effective July 1, 1970, home health services must be provided for any individual who, under the State plan, is entitled to skilled nursing-home services.

**Question 36**

**Do States evaluate the quality and quantity of the care provided?**

Yes. States must maintain a continuous review of services to ensure that high medical standards are achieved at the same time concepts of efficiency and economy are observed.

**Question 37**

**Will Medicaid pay the monthly premiums for Medicare's supplementary medical insurance?**

Until January 1, 1970, States can "buy in"—that is, they may enter into agreements to pay the premium charges under Part B for all Medicaid recipients 65 and over. Federal matching is not available, however, for the premium payments for those in the medically needy group. After January 1, 1970, Federal matching will not be available for any expenditures for Medicaid services that would have been provided to an individual by Medicare if the individual involved had been enrolled in the insurance program.

**Question 38**

**Does the program include family planning services?**

A State plan may include this type of service (see Question 33, item 15). If it does, it should interpret the service to include necessary drugs, supplies, and devices. Family planning services can also be

made available to Medicaid patients as part of physicians' care (see Question 33, item 5).

Under Title IV A of the Social Security Act, States are required to offer family planning services to all appropriate AFDC recipients.

No pressure, however, may be exerted on needy people to accept services of this type.

**Question 39**

**Is everyone who is eligible under a State Medicaid program eligible for the same care and services?**

The medical care and services must be the same for everyone in the State who is, or would be, eligible for federally aided financial assistance with the following exceptions:

- (1) The medical care services provided through "buying in" under the health insurance program for people aged 65 or older do not have to be provided to other recipients.
- (2) Skilled nursing-home care may be limited to people aged 21 or over.
- (3) Care in institutions for tuberculosis or mental diseases may be limited to people aged 65 or older.

For all Medicaid recipients classified as "medically needy," the kind and amount of medical care and services must be the same, with the following exceptions:

- (1) Skilled nursing-home care may be limited to people aged 21 or over.
- (2) The medical care services provided through "buying in" under the health insurance program for people aged 65 or older do not have to be provided to other medically needy recipients.
- (3) Care in institutions for tuberculosis or mental diseases may be limited to people aged 65 or older.

A State cannot provide more in the way of services for those who are only medically needy than for recipients of money payments, but it can provide less.

**Question 40**

**May the patient choose his own practitioner?**

Beginning July 1, 1969, States must allow anyone covered by Medicaid free choice among practitioners qualified and willing to accept the individual as a patient. The recipient is also to have free choice of qualified medical facilities and community pharmacies.

The free-choice principle includes the right to choose a qualified group of physicians organized in group practice, as well as to choose a

qualified physician. By group practice is meant not only a voluntary association of three or more physicians working as a team, but also a consumer-sponsored, prepaid, group practice medical care program. In the latter, an applicant could have his prepayment fees or dues paid to the group by the single State agency administering the program. There would have to be, however, an agreement between the agency and the group, making clear the care and services covered by the fees or dues.

**Question 41**

**The Act refers to medical care of "high quality." How can high quality be attained in a system that of necessity varies significantly from State to State?**

A State provides medical assistance in accordance with its financial resources and social philosophy. High-income States may be able to provide practically all the services anyone could need. States with low per capita income, even with the higher proportion of Federal dollars allotted them, may, of necessity, develop less comprehensive plans. Similar differences have characterized the grant-in-aid programs from the beginning. Nevertheless, the legislation that established the medical assistance program clearly calls for concerted effort by both Federal and State administrators to develop a program that is sound, acceptable, and moving toward excellence.

Even if a program must be limited to relatively few people and restricted in the amount, duration, and scope of service, it is expected to be of high quality. Definitions of the items of medical care listed in the law have been developed by the Medical Services Administration.

One of the major responsibilities of a State's medical advisory committee is to ensure that the medical care and services made available to recipients are in no way inferior to those enjoyed by the rest of the population.

Provisions of State programs should encourage full participation of all physicians. Accommodations in hospitals may not be less desirable than the semiprivate ones assured patients under Medicare. Hospital fees must be based on the reasonable cost of inpatient hospital services. All these measures, and others, are designed to ensure high-quality care.

## **INSTITUTIONAL REQUIREMENTS**

### **Question 42**

#### **Which hospitals may a Medicaid patient use?**

The hospital must be licensed or formally approved by an officially designated State standard-setting authority. It must also be certified to provide care under the Medicare program or be determined currently to meet the requirements (including the provisions of the Civil Rights Act) for certification, and it must have in effect a hospital utilization review plan applicable for all patients who receive medical assistance.

### **Question 43**

#### **Are most hospitals approved under one of these programs?**

Yes, more than 99 percent of the hospitals in the country have been certified. Some of the smaller hospitals have been unable to meet all the standards.

### **Question 44**

#### **Must skilled nursing-home services be provided under Medicaid?**

Skilled nursing-home services must be provided, if they are needed, for everyone aged 21 or over who is categorically needy. Such services may be provided, at a State's option, for the medically needy (see Question 35). Beginning July 1, 1970, a State providing skilled nursing-home services must also provide home health-care services.

### **Question 45**

#### **Are standards required for skilled nursing homes?**

Yes. A State must have an officially designated licensing authority responsible for setting and maintaining standards for all institutions, including nursing homes, in which recipients of medical assistance receive care. In addition to State licensure, homes must, after December 1968, meet specific Federal standards. After July 1, 1969, States will have to make periodic medical evaluations of the appropriateness of care provided Medicaid patients in nursing homes. In addition, beginning July 1, 1970, the administrator of a skilled nursing home must be licensed by the State (see Questions 48 and 49).



**Question 46**

**Can nursing homes that don't qualify as skilled nursing homes be used for medicaid patients?**

No. Title XIX provides for nursing home services only in skilled nursing homes. However, the 1967 amendments provide for "intermediate care" for anyone who is eligible for federally aided assistance payments (except under the AFDC program) and who does not have an illness, disease, or other condition requiring care and treatment in a hospital or skilled nursing home but needs more than boarding-home care. The homes must meet the same safety, sanitation, and licensing standards as skilled nursing homes. Federal participation is authorized under the money payment programs, not the Medicaid program.

Federal sharing in the cost, if the State chooses, is at the same rate as in the Medicaid program.

**Question 47**

**How can information be obtained on whether a nursing home qualifies as a skilled nursing home under Medicaid?**

Information may be obtained from the State or local agency responsible for the Medicaid program in the area in which the home is located.

**Question 48**

**Are there any qualifications for nursing-home administrators?**

Starting July 1, 1970, administrators of nursing homes will have to be licensed by the State. An administrator currently operating a home who does not qualify by that date will have 2 more years in which to do so. States must offer training programs to assist administrators to qualify. The Federal Government will share the cost of these training programs.

**Question 49**

**What is the National Advisory Council on Nursing Home Administration?**

The Secretary of HEW, under statutory authority, has set up a council to advise him and the States on the development of standards and procedures for the licensing of nursing home administrators.

The 9-member council includes distinguished representatives of State health and welfare agencies, universities offering programs in medical care administration, and the institutions and professions that care for infirm, aged, and chronically ill patients. It will report to the Secretary by July 1, 1969.

**Question 50**

**Will States help nursing homes and other medical institutions qualify to take part in the Medicaid program?**

Yes. Starting July 1, 1969, the States must provide consultant services to medical institutions to help them qualify for participation in Medicaid and other health programs under the Social Security Act. The Federal Government will share in the costs.

## **REIMBURSEMENT FOR CARE AND SERVICES**

**Question 51**

**What is the basis for payments to the suppliers of medical care and services?**

Hospitals are reimbursed for inpatient care on the basis of reasonable cost. The objective is to ensure that payments under Medicaid will meet the fair share of hospital costs for recipients.

Other suppliers of medical services are reimbursed according to State policies. Federal policy recommends reimbursement of institutions on the basis of reasonable cost and encourages the payment of reasonable fees to individual suppliers.

The 1967 amendments authorized the Secretary of HEW to approve experiments with new ways of reimbursement that promise more efficient methods of providing medical care and services without adversely affecting their quality.

**Question 52**

**Can the States make payment directly to the patient?**

If the patient is a recipient of federally supported financial assistance, States must pay the physician or facility providing the medical care and services directly.

If a patient is not receiving cash assistance, States have the option of paying patients for physicians' and dentists' services; it then becomes the patient's responsibility to pay for the care received.

**Question 53**

**Does the patient have to pay for any of the medical care or services provided by Medicaid programs?**

A State may require medically needy patients to pay a "deductible" and "coinsurance" for hospital care, medical care, or other services received, including part or all of the deductibles and coinsurance under Medicare. Income in excess of the amount specified by the State must also be applied to medical care costs. However, any cost sharing must be reasonably related to the individual's income or his income and resources.

**Question 54**

**Is there any limit on the amount the suppliers of services may charge?**

States are required to make sure that payments for medical care and services, including drugs, are reasonable and consistent with efficiency, economy, and quality of care.

**Question 55**

**Are Medicaid care and services available for eligible patients who have some health insurance?**

Yes. States must make sure, however, that health insurance benefits are used before payment is made under Medicaid. If a bill has already been paid by Medicaid and it is later found that insurance coverage was available, States will take steps to secure reimbursement.

## **SOCIAL SERVICES**

**Question 56**

**Are necessary social, as well as medical, services provided under Medicaid?**

Yes. States must provide for the development of necessary social services to help ill or disabled people make the best use of the medical care provided and deal with their health-related problems.

## **CARE FOR THE AGED IN INSTITUTIONS FOR MENTAL DISEASES AND TUBERCULOSIS**

### **Question 57**

**Is medical care for people in institutions for mental diseases and tuberculosis covered by Medicaid?**

States may, if they wish, make payments for people aged 65 or over in institutions for mental diseases or tuberculosis.

### **Question 58**

**If a State doesn't establish a Medicaid program, is there any way it can receive Federal funds to help meet the costs of care for people aged 65 and over in hospitals for mental diseases or tuberculosis under its existing programs?**

Yes. States may provide both money payments and medical assistance to needy aged people in hospitals for mental diseases or tuberculosis under their existing public assistance programs.

### **Question 59**

**Must States meet specific conditions or requirements to receive Federal funds for people aged 65 or over who are patients in hospitals for mental diseases or tuberculosis?**

Receipt of Federal funds is conditioned on specific requirements if the needy aged person is in a hospital for mental diseases but not if he is in a hospital for tuberculosis.

### **Question 60**

**What requirements must a State meet to obtain Federal sharing in the cost of care for aged people in hospitals for mental diseases?**

To qualify for Federal funds, a State must establish measures to ensure care of high quality, including provision for periodic evaluation of the patient's treatment and progress; prompt consideration of release to an appropriate living arrangement when institutional care is no longer necessary, and arrangements for the medical and social services needed for living in the community.

If a State provides medical assistance for older people in public institutions for mental diseases, it must show satisfactory progress toward developing and implementing a comprehensive mental health

program (including provision for use of community mental health centers, nursing homes, and other alternatives to care in public institutions for mental diseases).

**Question 61**

**Are Medicaid benefits available to the mentally retarded?**

In general, Medicaid benefits are available in the State to the mentally retarded on the same basis as benefits are available to other potentially eligible persons.

**Question 62**

**Are Federal funds available to help pay the salaries and other costs involved in providing social services to individuals who are released from hospitals for mental diseases to alternative forms of care, such as their own homes, foster care, or nursing homes?**

Yes, when the alternative forms of care are included among the services paid for by the agency administering the medical assistance program.

## **PROVISION FOR APPEALS**

**Question 63**

**Can a person appeal if he is dissatisfied with agency action on his claim for medical assistance?**

An opportunity for a fair hearing before the State agency administering the program must be granted to anyone requesting a hearing because his claim was denied or was not acted upon with reasonable promptness or because he feels aggrieved by any other action affecting his receipt of medical assistance.

**Question 64**

**Can anyone who is seeking a fair hearing be represented by legal counsel?**

Anyone requesting a fair hearing must be notified in writing that he may be represented by others, including legal counsel, and of any provision the State makes for payment of legal fees.

**Question 65**

**When the fair hearing involves medical issues, is there provision for obtaining an assessment by medical authorities other than those making the original decision?**

Yes. At the request of the person seeking the hearing, a second assessment must be obtained at agency expense from a medical source satisfactory to him. The hearing officer can also request evidence in addition to the physician's report in the original record.

## **SAFEGUARDING INFORMATION**

**Question 66**

**Is information concerning an individual's physical condition or social and economic circumstances regarded as confidential?**

The law provides safeguards that restrict the disclosure or use of information about applicants and recipients to purposes directly connected with the administration of the program.

**Question 67**

**May States make available for general inspection the records of disbursements in behalf of Medicaid recipients?**

States may not make available for general inspection the records on medical care and medical care costs for individual medicaid recipients.

## **NONDISCRIMINATION**

**Question 68**

**Is Medicaid operated without regard to race, color, or national origin?**

Yes. Title VI of the Civil Rights Act requires that all programs receiving Federal financial assistance must extend services to all, without

regard to race, color, or national origin. Discrimination exists when a person is treated differently because of his race, color, or national origin.

**Question 69**

**What State agency is responsible for compliance with the Civil Rights Act under Medicaid?**

The single State agency designated to administer the Medicaid program is responsible for compliance with the civil rights aspects of the program. This includes ensuring compliance by all political subdivisions when the plan is locally administered. The State agency must also ensure that all agencies, institutions, organizations, and practitioners or physicians, with whom State or local agencies have contractual or other arrangements, comply with the law.

**Question 70**

**What must the State agency do to ensure compliance with the civil rights provisions?**

The State agency must submit a statement showing that the State plan is being, and will continue to be, administered in such a way that no one will, because of race, color, or national origin, be excluded from participation in, be denied aid, care, or service, or other benefits of, or be otherwise subjected to discrimination in the program. It must also describe how it ensures compliance on a continuing basis.

**Question 71**

**Must hospitals and nursing homes participating in the medical assistance program comply with the civil rights provisions?**

Yes. Every statement of compliance accepted by the Department of Health, Education, and Welfare from State agencies receiving grants of Federal funds requires that no vendor payments or contractual or other arrangements involving Federal funds be approved for a hospital or nursing home that is not in compliance with the Civil Rights Act.

**Question 72**

**What must participating hospitals or nursing homes do to comply with the Civil Rights Act?**

They must treat every patient without discrimination in regard to race, color, or national origin. Compliance involves admission policies, room assignments, staff privileges, and availability of services and facilities. Patients may not be segregated in wings, floors, wards, or

rooms on the basis of race, color, or national origin. The State agency arranges for periodic on-site inspections of nursing homes and hospitals and may also require periodic reports from them.

**Question 73**

**What can the State agency do to enforce a policy of nondiscrimination?**

The agency should work with the noncomplying vendor to bring about voluntary compliance. If its efforts are unsuccessful, funds to that vendor may be cut off. The procedures will vary slightly from State to State, but the objective is always the same: to see that all vendors in federally assisted programs follow the policy and practice of no discrimination because of race, color, or national origin.

**Question 74**

**If anyone believes that he has been discriminated against because of race, color, or national origin, what can he do?**

He can register a formal complaint with the State agency administering the program or with the U.S. Department of Health, Education, and Welfare in Washington, D.C. The Department's Regulation requires a prompt investigation of such complaints.



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